MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

COMPANION GUIDE FOR THE HIPAA 837 INSTITUTIONAL CLAIM ADDENDA VERSION 4010A1

July 1, 2003

Effective for Claims Submitted On or After June 16, 2003

Michigan Department of Community Health

MDCH

MSA MEDICAL SERVICES ADMINISTRATION

This document is intended as a companion to the **Electronic Data Interchange Transaction Set Implementation Guide Health Care Claim: Institutional Claim Addenda, ASC X12N 837 (004010X096A1)**, dated October 2002, and the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Institutional Claim Addenda, ASC X12N 837 (004010X096)**, dated May 2000. This document should be used in conjunction with all MDCH claim submission and claim processing guidelines. This document follows guidelines authorized by the Department of Health and Human Services (HHS) on September 17, 2001. The clarifications include:

- identifiers to use when a national standard has not been adopted [and]
- parameters in the implementation guide that provide options

(The Addenda implementation guide can be found at http://www.wpc-edi.com/hipaa/hipaa_40.asp. HHS guidance on data clarifications can be found at http://aspe.os.dhhs.gov/admnsimp/q0321.htm.)

NOTE: ***Page references*** from the Implementation Guides refer to the **Electronic Data Interchange Transaction Set Implementation Guide Health Care Claim: Institutional Claim ASC X12N 837 (004010X098)** ("Version 4010"), unless otherwise noted (with an asterisk (*)) as referring to the Addenda Implementation Guides ("Version 4010A1"), **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Institutional Claim Addenda, ASC X12N 837 (004010X098A1)**.

Page*	Loop	Segment	Data Element	Comments
56		ST – Transaction Set Header		MDCH accepts a maximum of 5,000 CLM segments in a single transaction (ST-SE) as recommended by the HIPAA-mandated implementation guide.
59		BHT – (Header) Beginning of Hierarchical Transaction	BHT06 – Transaction Type Code	Use “CH” (Chargeable).
11*		REF – (Header) Transmission Type Identification	REF02 – Transmission Type Code	Use “004010X096A1” if using October 2002 Addenda Implementation Guide.
63	1000A – Submitter Name	NM1 – Submitter Name	NM109 – Submitter Identifier	Use the 4-character billing agent ID assigned by MDCH. This value should match GS02 (Application Sender’s Code)
68	1000B – Receiver Name	NM1 – Receiver Name	NM109 – Receiver Primary Identifier	Use “D00111” for MDCH.
69	2000A – Billing/Pay-to Provider Hierarchical Level	HL – Hierarchical Level	HL01 – Hierarchical ID Number	HL01 must begin with “1” and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.
77	2010AA – Billing Provider Name	NM1 – Billing Provider Name	NM108 – Identification Code Qualifier	Use “24” (EIN) or “34” (SSN).
78	2010AA – Billing Provider Name	NM1 – Billing Provider Name	NM109 – Billing Provider Identifier	Use the same EIN or SSN value submitted when registering the MDCH provider identifier used in Loop 2010AA REF02 (Billing Provider Additional Identifier).
83	2010AA – Billing Provider Name	REF – Billing Provider Secondary Information	REF01 – Reference Identification Qualifier	Use “1D”.
84	2010AA – Billing Provider Name	REF – Billing Provider Secondary Information	REF02 – Billing Provider Additional Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID).
102	2000B – Subscriber Hierarchical Level	SBR – Subscriber Information	SBR01 – Payer Responsibility Sequence Number Code	Use “P” if MDCH is the only payer (that is, patient has no Medicare or other insurance), “S” if there is one other payer, and “T” if there are two or more other payers.

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104	2000B – Subscriber Hierarchical Level	SBR – Subscriber Information	SBR09 – Claim Filing Indicator Code	Use “MC” for Medicaid, “TV” for CSHCS (Title V), or “11” for State Medical Plan (Other Non-Federal). If beneficiary qualifies for more than one program, or other MDCH program not listed, use “MC”.
110	2010BA – Subscriber Name	NM1 – Subscriber Name	NM108 – Identification Code Qualifier	Use “MI”.
110	2010BA – Subscriber Name	NM1 – Subscriber Name	NM109 – Subscriber Primary Identifier	Use the patient’s 8 character beneficiary ID number assigned by MDCH.
127	2010BC – Payer Name	NM1 – Payer Name	NM108 – Identification Code Qualifier	Use “PI”.
128	2010BC – Payer Name	NM1 – Payer Name	NM109 – Payer Identifier	Use “D00111” for MDCH.
139	2000C – Patient Hierarchical Level	HL – Hierarchical Level		MDCH business rules require that the patient is always the subscriber. Therefore, MDCH does not expect providers to submit any Loop 2000C Patient Hierarchical Levels in a transaction set. Transaction sets that contain Loop 2000C Patient Hierarchical Level information will be rejected.
158	2300 – Claim Information	CLM – Health Claim Information	CLM01 – Claim Submitter Identifier	Note that the HIPAA-mandated implementation guide allows a maximum of 100 repetitions of the 2300 CLM within each Loop 2000B (Subscriber Hierarchical Level). Transaction sets that do not associate Loop 2300 Claim Information with Loop 2000B Subscriber Hierarchical Levels, will be rejected.
159	2300 – Claim Information	CLM – Health Claim Information	CLM05-3 – Claim Frequency Code	See the Michigan Uniform Billing Manual for acceptable codes (This is the third position of FL04 Type of Bill.) If value is “7” (claim replacement) or “8” (void/cancel), include the MDCH-assigned CRN of the last approved claim as indicated in Loop 2300 REF02 – Original Reference Number ICN/DCN).
191	2300 – Claim Information	REF – Original Reference Number (ICN/DCN)	REF01 – Reference Identification Qualifier	Use when submitting a claim replacement or void/cancel (as indicated by Loop 2300 CLM05-3), use “F8”.
192	2300 – Claim Information	REF – Original Reference Number (ICN/DCN)	REF02 – Claim Original Reference Number	Use the 10-character CRN assigned by MDCH to the last approved claim.

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197	2300 – Claim Information	REF – PEER Review Organization (PRO) Approval Number	REF01 – Reference Identification Qualifier	Use “G4”.
197	2300 – Claim Information	REF – PEER Review Organization (PRO) Approval Number	REF02 – Peer Review Authorization Number	Use the 9-character number assigned by the Admission and Certification Review Contractor.
198	2300 – Claim Information	REF – Prior Authorization Number	REF01 – Reference Identification Qualifier	Use “G1”.
199	2300 – Claim Information	REF – Prior Authorization Number	REF02 – Prior Authorization Number	Use the 9-character Prior Authorization number assigned by MDCH.
208	2300 – Claim Information	NTE – Billing Note	NTE01 – Note Reference Code	Use “ADD”.
209	2300 – Claim Information	NTE – Billing Note	NTE02 – Billing Note Text	Provide free-text remarks, if needed.
232 – 240	2300 – Claim Information	HI – Other Diagnosis	HI01-1, HI02-1, …, HI12-1 – Diagnosis Code	Use “BF” (ICD-9-CM Diagnosis). Do not use a decimal point.
242	2300 – Claim Information	HI – Principal Procedure Information	HI01-1 – Code List Qualifier Code	Use “BR” (ICD-9-CM Principal Procedure).
243	2300 – Claim Information	HI – Principal Procedure Information	HI01-2 – Principal Procedure Code	See the ICD-9 CM Code book for acceptable procedure codes.
244 – 255	2300 – Claim Information	HI – Other Procedure Information	HI01-1, HI02-1, …, HI12-1 – Code List Qualifier Code	Use “BQ” (ICD-9-CM Procedure).
245 – 255	2300 – Claim Information	HI – Other Procedure Information	HI01-2, HI02-2, …, HI12-2 – Procedure Code	See the ICD-9 CM Code book for acceptable procedure codes.
256 – 266	2300 – Claim Information	HI – Occurrence Span Information	HI01-2, HI02-2, ..., HI12-2 – Occurrence Span Code	See the Michigan Uniform Billing Manual for acceptable codes.
268 – 278	2300 – Claim Information	HI – Occurrence Information	HI01-2, HI02-2, ..., HI12-2 – Occurrence Code	See the Michigan Uniform Billing Manual for acceptable codes.

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281 – 291	2300 – Claim Information	HI – Value Information	HI01-2, HI02-2, ..., HI12-2 – Value Code	See the Michigan Uniform Billing Manual for acceptable codes.
290	2300 – Claim Information	HI – Condition Information	HI01-2, HI02-2, ..., HI12-2 – Condition Code	See the Michigan Uniform Billing Manual for acceptable codes.
323	2310A – Attending Physician Name	NM1 – Attending Physician Primary Identifier	NM108 – Identification Code Qualifier	Use “24” (EIN) or “34” (SSN).
323	2310A – Attending Physician Name	NM1 – Attending Physician Primary Identifier	NM109 – Attending Physician Primary Identifier	Use the EIN or SSN value assigned to the MDCH provider identified in Loop 2310A REF02 (Attending Physician Secondary Identifier).
326	2310A – Attending Physician Name	REF – Attending Physician Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D”.
327	2310A – Attending Physician Name	REF – Attending Physician Secondary Identification	REF02 – Attending Physician Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID).
330	2310B – Operating Physician Name	NM1 – Operating Physician Secondary ID	NM108 – Identification Code Qualifier	Use “24” (EIN) or “34” (SSN).
330	2310B – Operating Physician Name	NM1 – Operating Physician Secondary ID	NM109 – Operating Physician Primary Identifier	Use the EIN or SSN value assigned to the MDCH provider identified in Loop 2310B REF02 (Operating Physician Secondary Identifier).
333	2310B – Operating Physician Name	REF – Operating Physician Secondary ID	REF01 – Reference Identification Qualifier	Use “1D”.
334	2310B – Operating Physician Name	REF – Operating Physician Secondary ID	REF02 – Operating Physician Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID).
337	2310C – Other Provider Name	NM1 – Other Provider Secondary Identification	NM108 – Identification Code Qualifier	Use “24” (EIN) or “34” (SSN).

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Page*	Loop	Segment	Data Element	Comments
337	2310C – Other Provider Name	NM1 – Other Provider Secondary Identification	NM109 – Other Provider Primary Identifier	Use the EIN or SSN value assigned to the MDCH provider identified in Loop 2310C REF02 (Other Provider Secondary Identifier).
340	2310C – Other Provider Name	REF – Other Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D”.
341	2310C – Other Provider Name	REF – Other Provider Secondary Identification	REF02 – Other Provider Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID).
350	2310E – Service Facility Name	NM1 – Service Facility Secondary Identification	NM108 – Identification Code Qualifier	Use “24” (EIN) or “34” (SSN).
350	2310E – Service Facility Name	NM1 – Service Facility Secondary Identification	NM109 – Laboratory or Facility Primary Identifier	Use the EIN or SSN value assigned to the MDCH provider identified in Loop 2310E REF02 (Service Facility Secondary Identifier).
357	2310E – Service Facility Name	REF – Service Facility Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D”.
358	2310E – Service Facility Name	REF – Service Facility Secondary Identification	REF02 – Laboratory or Facility Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID).
359	2320 – Other Subscriber Information	SBR – Subscriber Information		If the patient has other insurance (Medicare, for example) repeat this loop for each other payer. Do not put information about MDCH coverage in this loop.
360	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR01 – Payer Responsibility Sequence Number Code	If the patient has other insurance, report primary payer coverage with code “P”, a secondary payer with code “S”, and all other insurance coverage with code “T” as appropriate.
361	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR02 – Individual Relationship Code	The code carried in this element is the patient’s relationship to the person who is insured. For example, if a child has BCBSM coverage under his father’s insurance, use code 19 (Child).

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363	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR03 – Insured Group or Policy Number	Use the subscriber's group number (assigned by the other payer), not the number that uniquely identifies the subscriber. For example, group numbers assigned by BCBSM are usually 5 digits.
363	2320 – Other Subscriber Information	SBR – Subscriber Information	SBR09 – Claim Filing Indicator Code	Do not use "MC", "TV", or "11" in this element.
365	2320 – Other Subscriber Information	CAS – Claim Level Adjustment		Required if claim has been adjudicated by payer identified in this loop and has claim level adjustment information.
401 – 402	2330A – Other Subscriber Name	NM1 – Other Subscriber Name	NM103, NM104, NM105 – Other Insured: Last Name, First Name, Middle Name	Use the name of the subscriber as it appears on the files of the other payer.
402	2330A – Other Subscriber Name	NM1 – Other Subscriber Name	NM108 – Identification Code Qualifier	Use "MI".
403	2330A – Other Subscriber Name	NM1 – Other Subscriber Name	NM109 – Other Insured Identifier	Use the unique member number assigned to the subscriber by the other payer indicated in loop 2330B. For example, member numbers assigned by BCBSM are usually 3 letters followed by 9 digits.
408	2330A – Other Subscriber Name	REF – Other Subscriber Secondary Information	REF01 – Reference Identification Qualifier	Do not use "1W".
411	2330B – Other Payer Name	NM1 – Other Payer Name	NM108 – Identification Code Qualifier	Use "PI".
411	2330B – Other Payer Name	NM1 – Other Payer Name	NM109 – Other Payer Primary Identifier	See the Michigan Uniform Billing Manual for acceptable Payer Identification Codes to be used in conjunction with the carrier code assigned by MDCH (see MDCH website for a listing of carrier codes). Example values for this field: BCBSM Traditional would be "G00029005"; Medicare Part A (United Government Services) would be "C00452"; and Medicare Part B (Wisconsin Physician Services) would be "C00953".
426	2330D – Other Payer Attending Provider	REF – Other Payer Attending Provider ID	REF01 – Reference Identification Qualifier	Do not use "1D".

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Page*	Loop	Segment	Data Element	Comments
430	2330E – Other Payer Operating Provider	REF – Other Payer Operating Provider ID	REF01 – Reference Identification Qualifier	Do not use “1D”.
434	2330F – Other Payer Other Provider	REF – Other Payer Other Provider ID	REF01 – Reference Identification Qualifier	Do not use “1D”.
438	2330G – Other Payer Referring Provider	REF – Other Payer Referring Provider ID	REF01 – Reference Identification Qualifier	Do not use “1D”.
442	2330H – Other Payer Service Facility Provider	REF – Other Payer Service Facility Provider ID	REF01 – Reference Identification Qualifier	Do not use “1D”.
444	2400 – Service Line Number	LX – Assigned Service Line Number	LX01 – Assigned Number	MDCH recommends submitting 50 or fewer service lines for each institutional claim. Claims submitted with more than 50 service lines may be subject to processing delays.
446	2400 – Service Line Number	SV2 – Institutional Service Line Number	SV201 – Service Line Revenue Code	See the Michigan Uniform Billing Manual for acceptable codes.
447	2400 – Service Line Number	SV2 – Institutional Service Line Number	SV202-2 – Procedure Code	See the Michigan Uniform Billing Manual for acceptable codes.
449	2400 – Service Line Number	SV2 – Institutional Service	SV206 – Service Line Rate	Unit Rate greater than or equal to zero is required on all service lines.
454	2400 – Service Line Number	PWK – Paperwork	PWK02 – Attachment Transmission Code	Billing Notes can be provided in Loop 2300 NTE02.
35*	2410 – Drug Identification	LIN – Item Identification	LIN03 – Product/Service ID	MDCH will only process the first repeat of 2410 LIN. All additional repeats will be ignored.
490	2430 – Service Line Adjudication Information			MDCH expects this loop for each payer identified in Loop 2320 (Other Subscriber Information), except when that payer has adjudicated this claim at the claim level.

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